Journal of Forensic and Legal Medicine 20 (2013) 732–735

Contents lists available at SciVerse ScienceDirect

Journal of Forensic and Legal Medicine

journal homepage: www.elsevier.com/locate/jflm

Original communication

General practitioners and managing domestic violence: Results of a qualitative study in Germany

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ARTICLE INFO

Article history:
Received 2 February 2013
Accepted 27 April 2013
Available online 28 May 2013

Keywords:
Domestic violence
Clinical forensic medicine
General practitioners
Case management

ABSTRACT

A qualitative interview based study on ways of addressing and managing domestic violence (DV) by general practitioners (GPs) is presented. Problem centred semi-structured topic-guided interviews were conducted with 10 male and nine female GPs. Transcribed passages were analysed with the deductive approach of qualitative content analysis. Female doctors gave broader definitions of DV. Addressing of DV by a patient was perceived as a demand to act by all doctors. Documentation of injuries was considered to be important. Time constraints, feelings of being ashamed and helpless were described as barriers in addressing DV. Female doctors reported being anxious about losing their professional distance in cases of female victims. While female participants tend to take an 'acting' role in managing cases of DV by being responsible for treatment and finding a solution in collaboration with the patient, male doctors preferred an 'organising' role, assisting patients finding further help. Definitions of DV and differences in addressing the issue seemed to be strongly affected by personal professional experience. Definitions of DV, personal barriers in addressing the subject and understanding of the own role in management and treatment of DV cases differed between male and female doctors. Pre-existing definitions of DV, personal experience and gender aspects have to be taken into account when planning educational programmes for GPs on the issue of DV.

1. Introduction

Clinical forensic medicine and examination of surviving victims of violence has become a growing field in forensic medicine. Nevertheless, only a portion of cases is examined by forensic specialists.[1] In order to foster everyday patient care quality for victims of violence, training of general practitioners (GP) on managing common forms of violence, especially domestic violence (DV), is an important issue that forensic specialists should be involved in to share their competencies and experiences. DV is a major public health problem. It has been shown, that 41% of women waiting to see their GP have experienced physical violence from a partner or former partner, 17% within the past year.[2] As DV can be causative or co-causative for a variety of health problems leading to consultation of a GP (e.g. injury, chronic pain, gastrointestinal and gynaecological conditions, depression, post-traumatic stress disorder and alcohol and drug abuse), understanding about DV and strategies for counselling and taking care of these patients are pivotal. This is not only of importance for patient care quality. Besides medical examination, information and treatment, the majority of abused women value empowerment and empathy through their physicians the most. This is of great importance for promoting disclosure of DV and initiating change.[3] Otherwise shame and fear of retaliation might avert disclosure, especially as not all patients are aware of the relationship between DV and physical symptoms.[4] On the other hand, the physicians' feeling of incapacity and powerlessness concerning the domestic situation can be barriers for assisting and supporting the victims.[5] A comprehensive training programme for GPs can have positive effects on the physicians' awareness, knowledge, case management and general confidence in

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1752-928X/$ – see front matter
http://dx.doi.org/10.1016/j.jflm.2013.04.008

addressing the subject.[6] However, trainees can have different professional experiences and beliefs about dealing with victims of DV: While some physicians believe that a more passive role would be appropriate (preventing unnecessary pressure), others emphasise that an active and promoting way of counselling is necessary to manage the problem. In addition, there appear to be gender differences among physicians. While female doctors believe DV to be a more serious health-care issue than their male counterparts and training seems to have a greater effect in women concerning the detection of abuse cases, male physicians appear to have a greater level of confidence in their abilities concerning the case management of DV.[6–8]

The purpose of this study is to identify differences in addressing and managing cases of DV by GPs using a qualitative approach.

2. Methods

At a workshop of GPs working as teaching doctors for medical students in Hamburg, Germany (metropolitan area in northern Germany), the aim and structure of the study were presented and GPs were asked to participate. Participation in the study was voluntary. Of the 60 attendees of the workshop, 28 agreed that they were interested in taking part in the study. Problem centred semi structured topic guided interviews were conducted with 19 GPs. Since no new aspects emerged during interviews, theoretical saturation was reached and no further interviews were organised. A short questionnaire was used to collect socio-demographic data. A post scriptum was prepared by the interviewer to reflect impressions, key aspects and possible disturbing factors. The topic guide was slightly modified and adopted during the first interviews. The final version is shown in Table 1. All interviews were recorded with full consent of the interviewees. In a first round of data collection, all interviews were listened to at least two times and summarised in written form. In a second round all relevant passages were transcribed. Data were analysed with the deductive approach of qualitative content analysis.[9]

3. Results

3.1. Sample characteristics

The sample consisted of 10 male and nine female GPs. Professional experience in general practice ranged from 1 year to 29 years (mean 13.5 years). Age ranged from 31 to 62 years (mean 49 years). Doctor's practices were located in different parts of the city of Hamburg (about 1.7 million inhabitants) including districts with higher and lower socio-economic level.

3.2. Definition of DV

DV was defined as physical and psychological violence by 11 participants, defining sexual violence as a subgroup of physical violence. Psychological violence was believed to be much more common than physical violence by these participants. DV was equalised with physical violence among family members by four interviewees. Physical, psychological and sexual violence were addressed as independent forms of violence by four participants, all being female.

Table 1
Topic guide used in conducting the interviews (DV = domestic violence).

Which kind of violence is addressed by the term DV?
How often do cases of DV occur in your everyday practice?
Which are the predominant forms of violence?
What are the ways of addressing the issue?
What is your personal professional experience with cases of DV?
Do you document injuries, if still visible?
What is your role as a doctor in helping victims of DV?

3.3. Addressing the issue of violence

All participants reported violence to be a rather rare issue in their daily practice. Frequency was reported to range from one case every 2 years to about 10 cases per year, with psychological violence being the most common form. Lower frequencies were reported by GPs working in districts with higher socio-economical level. GPs believed that patients with a higher level of education are more enabled to take steps of action on their own and therefore might not ask a GP for assistance.

Participants reported physical violence as a form of DV to be more often openly addressed by their patients, although they believe psychological violence to be more common. A direct addressing of violence by a patient was perceived as a demand to act by all interviewed doctors. All interviewees believed that several preceding contacts with the GP and an openness of the doctor are a requirement for the patient to talk openly. None of the participants had experiences with cases of sexual violence. Although they claimed to be aware of the problem, they did not feel responsible for dealing with this 'private' and 'intimate' issue but believed this to be a gynaecologist's duty.

Barriers identified in addressing the issue of violence by doctors were restricted opening hours, other patients waiting ('full waiting room'), own feelings of being ashamed or helpless and cultural and language barriers. On an avoidance of the subject due to their concern, female doctors reported that they might lose the professional role and distance to the patient, especially as victims of DV are most often females as well.

A refusal of patients to talk about violence issues was reported from several participants. Although they felt that it is important that the patient determines whether the issue is addressed in the doctor–patient relationship, they blamed themselves for having addressed the problem in a wrong way if the patient did not show up in the doctor's office again.

One female doctor reported to have included questions on the patient's social environment and psychosomatic symptoms into her regular anamnesis, making it easier for victims to address their problems. This led to the effect that several female victims of DV from other urban districts came to her doctor's office, being aware of her openness for the issue. Although victims of violence were described as time-consuming by this participant, she experienced this as 'time saving in the long-term,' because these patients do not have to see a GP several times to be able to address the problem.

In one case, a male doctor reported about repeated verbal threatening by a male perpetrator, claiming that the doctor was responsible for his marital split-up after he had encouraged the former wife to leave the perpetrator after several episodes of DV.

3.4. Documentation of DV

The interviewed GPs were aware of the necessity of documentation and claimed to document cases of DV adequately in written form and by taking pictures when the patient agrees and physical injuries are still apparent. Nevertheless, all were uncertain whether their documentation would be sufficient in the case of a trial in court. Some doctors thought that a standardised manual for documentation and a department for clinical forensic medicine within reachable distance would be helpful. However, documentations were rarely requested by court or other institutions.

3.5. Role concepts of GPs

While some doctors see themselves as 'actors', taking measurements in a partnership with the patient, others have the role concept of being an 'organiser', assisting their patients in finding help with support services. While more female interviewees tended to be 'actors', male doctors tended to take a more passive and 'organising' role.

'Actors' reported to be willing to deal with the patient's problem, being responsible for further treatment and being in charge to find a solution together with the patient, if the issue of DV is openly addressed by the victim. Some doctors perceiving themselves in the role of 'actors' objected to pharmacological treatment in cases of DV (e.g. with benzodiazepines) while most GPs believed temporary medical treatment to be an option to stabilise patients for a short period of time.

In contrast to 'actors', 'organisers' try to refer patients to relevant support and counselling services. When patients are willing to follow their advice and accept being referred to another expert, 'organisers' feel that they successfully have fulfilled their role. Cooperation with counselling services was reported to be more satisfying, when doctors were informed about the services and saw them as networking partners.

4. Discussion

In relation to the reported lifetime prevalence of DV in about 25% of women in Germany,[10] DV appears to be a rare phenomenon in daily practice, as perceived by the interviewed GPs. This may contribute to the fact that different personal definitions of DV were given by the interviewed doctors that may strongly be affected by personal experience. Broadest definitions of DV were given by female doctors. Interestingly, none of the interviewees mentioned social violence (e.g. isolation by not being allowed to leave the house independently) or economical violence (e.g. financial dependency by not being allowed to work) as independent forms of DV.

While the interviewed GPs reported to have experiences with cases of physical and psychological violence, all doctors negated cases of sexual violence in their everyday practice. While the interviewees' presumption that those patients might have consulted a specialist (gynaecologist) is conclusive, a direct verbal addressing of sexual violence in cases of DV might result in uncovering of cases that are not reported spontaneously.

All interviewed doctors understand a patients addressing of violence experiences as a demand to act and reported openness for the subject. Nevertheless, besides external barriers, which can hardly be overcome, especially female doctors reported about personal barriers such as 'shame' and fear of losing their professional relationship with the patient. The latter problems might be reduced or overcome by educational programmes and training, leading to a more effective and satisfying case management.[6]This is demonstrated by one of the interviewees in our sample who reported to be known as a kind of specialist in DV amongst her patients, leading to specific consultations of formerly unknown patients.

Documentation of injuries due to DV was identified as an important issue by all interviewees, but a reasonable precariousness was reported. The need for applicable manuals or web-based guidance was expressed.

Finally, the GPs expressed different understandings of their own role, being either 'organisers' or 'actors', the latter predominantly reported by female doctors. To our best knowledge, this has not been reported before, although being of importance when planning educational programmes or material for GPs.

A limitation of the presented study is the pre-selection bias of the participating GPs. They voluntarily registered for the interviews, therefore being interested in the study subject. An inclusion of doctors not familiar with or aware of DV might therefore lead to different or complementary results.

Our results confirm previous findings[6–8] of gender differences in perception, addressing and management of DV among doctors, in this case GPs. Furthermore, the results point at the doctors' professional experience with the issue being an additional important influencing factor. Although most clinicians tend to have a generally positive attitude towards women experiencing DV, their knowledge of possible intervention and management strategies appears to be in need of improvement.[11] Therefore, educational programmes are necessary. Gender differences and personal experience of the trainees have to be considered when planning future educational programmes or written manuals concerning the patient-centred care in cases of DV. In the case of interprofessional training, the differing roles, time constraints and level of patient interaction of health professionals have to be taken into account.[12,13] While female doctors tend to be more aware of the problem and to be more willing to address the issue openly and directly, they seem to have more personal barriers and misgivings at the same time, which can be reduced or overcome by training programmes that take individual experiences into account.[6] In addition, our results suggest that the doctors understanding of his or her own role of being either an 'actor' or 'organiser' has to be taken into account and fostered by either training on necessary communication and management skills or building a potential community network with counselling services and enhancing knowledge of local DV resources.[11]

Future educational programmes on the issue of DV addressing GPs should consider gender differences, varying experiences and own role concepts of the participants in order to earn the most effective outcome concerning an amendment of patient-centred care in cases of DV.

Conflict of interest

All authors state that there are no personal or financial relationships with other people or organisations that could inappropriately influence their work concerning the presented study and the manuscript.

Funding

None.

Ethical approval

None.

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